GEORGIA DEPARTMENT OF COMMUNITY HEALTH

TOPICAL ANTIFUNGALS PA SUMMARY

PREFERRED	Ciclopirox (cream, suspension), Ketoconazole (cream, shampoo), Loprox gel, Miconazole
NON-PREFERRED	Ciclodan Kit, Ciclopirox (gel, shampoo), Econazole cream, Ertaczo (PA not required), Exelderm (PA not required), Extina foam (ketoconazole 2%), Ketoconazole 2% foam, Ketodan Kit, Loprox cream/suspension (PA not required), Loprox shampoo, Lotrisone lotion (PA not required), Mentax (PA not required), Naftin, Oxistat (PA not required), Vusion, Xolegel, Xolegel DUO, Xolegel Corepak (brand or generic)

LENGTH OF AUTHORIZATION: Varies

NOTE: If Ketoconazole foam is approved, the PA will be issued for the brand-name product, Extina. If ciclopirox shampoo is approved, the PA will be issued for the brand-name product, Loprox shampoo. PA criteria for ciclopirox solution (Ciclodan, CNL8, Penlac) is located in the "Oral Antifungals and Ciclopirox Soln" document.

PA CRITERIA:

For Ciclodan Kit

- Submit a written letter of medical necessity stating the reason(s) that generic ciclopirox cream 0.77% (preferred medication) is not appropriate for the member.

For Ciclopirox Gel

- Submit a written letter of medical necessity stating the reason(s) that brand-name Loprox gel 0.77% (preferred medication) is not appropriate for the member.

For Loprox (Ciclopirox) Shampoo

- Approvable for the diagnosis of seborrheic dermatitis

AND

- Provider should submit documentation of ineffectiveness, allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to generic ketoconazole shampoo.

For Ketoconazole Foam, Ketodan Kit, or Xolegel Products

- Approvable for members age 12 or older with a diagnosis of seborrheic dermatitis

AND

- Provider should submit a written letter of medical necessity stating the reason(s) the preferred product, generic ketoconazole cream or shampoo, is not appropriate for the member.

For Econazole or Naftin

- Provider should submit faxed documentation of trial and failure of at least one OTC or prescription topical antifungal agent that does not require prior authorization.

For Vusion

- Approvable for members age 4 weeks or older with a diagnosis of diaper dermatitis when the presence of a candidal infection has been confirmed by a microscopic evaluation

AND

- Provider should submit faxed documentation of trial and failure of a topical antifungal agent (OTC or prescription) within the past 60 days.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **Catamaran at 1-866-525-5827.**

PA and APPEAL PROCESS:

- For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on "prior approval process".

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limit please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.